FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038802

Facility Name: CARRINGTON CARE CENTER LTD

Address: 759 KANE STREET (Number) SOUTH ELGIN (City) 60177 (Zip Code)

County: KANE

Telephone Number: (847) 697-3310 **Fax #** (847) 697-3354

IDPA ID Number: 363892033001

Date of Initial License for Current Owners: 07/01/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) RICHARD S. SGARLATA, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	107	Skilled (SNF)	107	39,055	1
2		Skilled Pediatric (SNF/PED)			2
3	99	Intermediate (ICF)	99	36,135	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	206	TOTALS	206	75,190	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,051	1,142	2,226	6,419	8
9	SNF/PED					9
10	ICF	32,968	9,298	1,086	43,352	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,019	10,440	3,312	49,771	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.19%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 7/1/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 7/1/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 1880

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	274,897	19,088	7,704	301,689		301,689		301,689			1
2	Food Purchase		239,373		239,373	(30,441)	208,932	(530)	208,402			2
3	Housekeeping	157,601	30,107		187,708		187,708		187,708			3
4	Laundry	112,845	16,029		128,874		128,874	(422)	128,452			4
5	Heat and Other Utilities			140,983	140,983		140,983	912	141,895			5
6	Maintenance	33,943	23,927	38,902	96,772		96,772	9,694	106,466			6
7	Other (specify):*							1,388	1,388			7
8	**TOTAL General Services**	579,286	328,524	187,589	1,095,399	(30,441)	1,064,958	11,042	1,076,000			8
	B. Health Care and Programs											
9	Medical Director			19,500	19,500		19,500		19,500			9
10	Nursing and Medical Records	2,000,013	131,761	85,722	2,217,496		2,217,496	(2,048)	2,215,448			10
10a	Therapy	60,934	682	1,260	62,876		62,876		62,876			10a
11	Activities	125,954	5,380	2,340	133,674		133,674	(68)	133,606			11
12	Social Services	26,654		2,194	28,848		28,848		28,848			12
13	Nurse Aide Training							142	142			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,213,555	137,823	111,016	2,462,394		2,462,394	(1,974)	2,460,420			16
	C. General Administration											
17	Administrative	9,423			9,423		9,423	220,655	230,078			17
18	Directors Fees											18
19	Professional Services			370,191	370,191		370,191	(319,445)	50,746			19
20	Dues, Fees, Subscriptions & Promotions			52,776	52,776		52,776	(8,984)	43,792			20
21	Clerical & General Office Expenses	102,743	4,139	60,681	167,563		167,563	32,995	200,558			21
22	Employee Benefits & Payroll Taxes			404,313	404,313	30,441	434,754	(14,725)	420,029			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,470	1,470		1,470	1,018	2,488			24
25	Other Admin. Staff Transportation			12,342	12,342		12,342	130	12,472			25
26	Insurance-Prop.Liab.Malpractice			165,266	165,266		165,266	4,111	169,377			26
27	Other (specify):*							39,143	39,143			27
28	**TOTAL General Administration**	112,166	4,139	1,067,039	1,183,344	30,441	1,213,785	(45,102)	1,168,683			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,905,007	470,486	1,365,644	4,741,137		4,741,137	(36,034)	4,705,103			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number CARRINGTON CARE CENTER LTD #0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			29,379	29,379		29,379	22,826	52,205			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			51,358	51,358		51,358	(10,521)	40,837			32
33	Real Estate Taxes			135,165	135,165		135,165	2,150	137,315			33
34	Rent-Facility & Grounds			747,241	747,241		747,241		747,241			34
35	Rent-Equipment & Vehicles			13,742	13,742		13,742	8,798	22,540			35
36	Other (specify):*											36
37	TOTAL Ownership			976,885	976,885		976,885	23,253	1,000,138			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		69,636	43,360	112,996		112,996	(2,148)	110,848			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			112,785	112,785		112,785		112,785			42
43	Other (specify):*	37,551		600	38,151		38,151	(38,151)				43
44	TOTAL Special Cost Centers	37,551	69,636	156,745	263,932		263,932	(40,299)	223,633			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,942,558	540,122	2,499,274	5,981,954		5,981,954	(53,080)	5,928,874			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	18,958	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(499)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(19,855)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(6,100)	20		28
29	Other-Attach Schedule	(75,871)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (83,367)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	30,287		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 30,287		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (53,080)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

CARRINGTON CARE CENTER LTD

ID# 0038802

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	PPA - Contract Nursing	$ (889)	10	1
2	PPA - Activities	(68)	11	2
3	PPA - Dues	(201)	20	3
4	PPA - Clerical	(1,958)	21	4
5	PPA - Food	(31)	2	5
6	PPA - Employee Benefits	(14,725)	22	6
7	PPA - Laundry	(422)	4	7
8	PPA - Maintenance	(47)	6	8
9	Discounts Earned	(310)	10	9
10	Marekting Auto Expense	(600)	43	10
11	Marketing Salary	(37,551)	43	11
12	Collection Fees	(288)	19	12
13	Political Contributions - ICLTC	(3,930)	20	13
14	Interest Income	(12,734)	32	14
15	Capitalized Repairs & Maintenance	(630)	6	15
16	Bank Charges	(1,337)	21	16
17	Trust Fees	(150)	21	17
18				18
19				19
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STATE OF ILLINOIS

Summary A

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(530)											(530)	2
3	Housekeeping													3
4	Laundry	(422)											(422)	4
5	Heat and Other Utilities			912									912	5
6	Maintenance	(677)		4,727	5,644								9,694	6
7	Other (specify):*			976		412							1,388	7
8	**TOTAL General Services**	(1,629)		6,615	5,644	412							11,042	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,199)							(849)				(2,048)	10
10a	Therapy													10a
11	Activities	(68)											(68)	11
12	Social Services													12
13	Nurse Aide Training			142									142	13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(1,267)		142					(849)				(1,974)	16
	C. General Administration													
17	Administrative				220,655								220,655	17
18	Directors Fees													18
19	Professional Services	(288)		(319,157)									(319,445)	19
20	Fees, Subscriptions & Promotions	(10,231)		1,247									(8,984)	20
21	Clerical & General Office Expenses	(23,300)		50,765	5,530								32,995	21
22	Employee Benefits & Payroll Taxes	(14,725)											(14,725)	22
23	Inservice Training & Education													23
24	Travel and Seminar			1,018									1,018	24
25	Other Admin. Staff Transportation			130									130	25
26	Insurance-Prop.Liab.Malpractice			4,111									4,111	26
27	Other (specify):*			8,187		30,956							39,143	27
28	**TOTAL General Administration**	(48,544)		(253,699)	226,185	30,956							(45,102)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(51,440)		(246,942)	231,829	31,368			(849)				(36,034)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	18,958		3,868									22,826	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(12,734)		2,213									(10,521)	32
33	Real Estate Taxes			2,150									2,150	33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles			8,798									8,798	35
36	Other (specify):*													36
37	**TOTAL Ownership**	6,224		17,029									23,253	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(2,148)				(2,148)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(38,151)											(38,151)	43
44	**TOTAL Special Cost Centers**	(38,151)							(2,148)				(40,299)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(83,367)		(229,913)	231,829	31,368			(2,997)				(53,080)	45

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		Carrington Care Center Bldg. Corp.		Building
				See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 747,241	Carrington Care Center Building Corp.		$	$ (747,241)	1
2	V	34	Rent Expense		Carrington Care Center Building Corp.		747,241	747,241	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 747,241			$ 747,241	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 912	$ 912	15
16	V	6	REPAIRS & MAINT.		DYNAMIC HEALTH CARE CONS.	100.00%	4,727	4,727	16
17	V	7	EMP.BEN. - GEN. SERVICES		DYNAMIC HEALTH CARE CONS.	100.00%	976	976	17
18	V	13	NURSES AIDE TRAINING		DYNAMIC HEALTH CARE CONS.	100.00%	142	142	18
19	V	19	PROFESSIONAL FEES		DYNAMIC HEALTH CARE CONS.	100.00%	2,053	2,053	19
20	V	20	DUES AND SUBSCRIPTIONS		DYNAMIC HEALTH CARE CONS.	100.00%	1,247	1,247	20
21	V	21	CLERICAL & GENERAL		DYNAMIC HEALTH CARE CONS.	100.00%	50,765	50,765	21
22	V	24	SEMINARS AND TRAVEL		DYNAMIC HEALTH CARE CONS.	100.00%	1,018	1,018	22
23	V	25	ADMIN. STAFF TRANS.		DYNAMIC HEALTH CARE CONS.	100.00%	130	130	23
24	V	26	INSURANCE		DYNAMIC HEALTH CARE CONS.	100.00%	4,111	4,111	24
25	V	27	EMP.BEN. - GEN. ADMIN.		DYNAMIC HEALTH CARE CONS.	100.00%	8,187	8,187	25
26	V	30	DEPRECIATION		DYNAMIC HEALTH CARE CONS.	100.00%	3,868	3,868	26
27	V	32	INTEREST		DYNAMIC HEALTH CARE CONS.	100.00%	2,213	2,213	27
28	V	33	REAL ESTATE TAXES		DYNAMIC HEALTH CARE CONS.	100.00%	2,150	2,150	28
29	V	35	EQUIPMENT RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	8,798	8,798	29
30	V								30
31	V	19	HOME OFFICE BOOKKEEPING	321,210	DYNAMIC HEALTH CARE CONS.			(321,210)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 321,210			$ 91,297	$ * (229,913)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT. CMP. - D. NEHMER	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 5,644	$ 5,644	15
16	V	10	NURSING CMP - SUE G.		DYNAMIC HEALTH CARE CONS.	100.00%			16
17	V	17	ADMIN. CMP. - M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	34,997	34,997	17
18	V	17	ADMIN. CMP. - M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	47,296	47,296	18
19	V	17	ADMIN. CMP. - F. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			19
20	V	17	ADMIN. CMP. - S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.	100.00%	48,301	48,301	20
21	V	17	ADMIN. CMP. - S. KOPLIN		DYNAMIC HEALTH CARE CONS.	100.00%	10,079	10,079	21
22	V	17	ADMIN. CMP. - D. MAGAFAS		DYNAMIC HEALTH CARE CONS.	100.00%			22
23	V	17	ADMIN. CMP. - E. CASSON		DYNAMIC HEALTH CARE CONS.	100.00%	47,846	47,846	23
24	V	17	ADMIN. CMP. - S. BOGEN		DYNAMIC HEALTH CARE CONS.	100.00%			24
25	V	17	ADMIN. CMP. - S. LEVY		DYNAMIC HEALTH CARE CONS.	100.00%	12,269	12,269	25
26	V	17	ADMIN. CMP. - HOWARD ALTER		DYNAMIC HEALTH CARE CONS.	100.00%			26
27	V	17	ADMIN. CMP. - NON-OWNER		DYNAMIC HEALTH CARE CONS.	100.00%	19,867	19,867	27
28	V	21	CLERICAL CMP. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	5,530	5,530	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 231,829	$ * 231,829	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP. BEN.- D. NEHMER	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 412	$ 412	15
16	V	15	EMP. BEN.- SUE G.		DYNAMIC HEALTH CARE CONS.	100.00%			16
17	V	27	EMP. BEN.- M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	2,234	2,234	17
18	V	27	EMP. BEN.- M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	3,261	3,261	18
19	V	27	EMP. BEN.- F. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			19
20	V	27	EMP. BEN.- S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.	100.00%	6,058	6,058	20
21	V	27	EMP. BEN.- S. KOPLIN		DYNAMIC HEALTH CARE CONS.	100.00%	2,311	2,311	21
22	V	27	EMP. BEN.- D. MAGAFAS		DYNAMIC HEALTH CARE CONS.	100.00%			22
23	V	27	EMP. BEN.- E. CASSON		DYNAMIC HEALTH CARE CONS.	100.00%	11,976	11,976	23
24	V	27	EMP. BEN.- S. BOGEN		DYNAMIC HEALTH CARE CONS.	100.00%			24
25	V	27	EMP. BEN.- S. LEVY		DYNAMIC HEALTH CARE CONS.	100.00%	1,703	1,703	25
26	V	27	EMP. BEN.- HOWARD ALTER		DYNAMIC HEALTH CARE CONS.	100.00%			26
27	V	27	EMP. BEN.- NON-OWNER		DYNAMIC HEALTH CARE CONS.	100.00%	2,671	2,671	27
28	V	27	EMP. BEN. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	742	742	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 31,368	$ * 31,368	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	THERAPY	$ 1,260	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	$ 1,260	$	15
16	V	19	PROFESSIONAL FEES		DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%			16
17	V	22	EMPLOYEE BENEFITS		DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%			17
18	V	39	ANCILLARY SERVICES	43,360	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	43,360		18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 44,620			$ 44,620	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING & MEDICAL SUPPLY	$ 26,676	PHARMCOR, L.L.C.	100.00%	$ 26,676	$	15
16	V	19	PROFESSIONAL FEES		PHARMCOR, L.L.C.	100.00%			16
17	V	21	CLERICAL & GENERAL	299	PHARMCOR, L.L.C.	100.00%	299		17
18	V	22	EMPLOYEE BENEFITS		PHARMCOR, L.L.C.	100.00%			18
19	V	39	ANICILLARY EXPENSE	32,798	PHARMCOR, L.L.C.	100.00%	32,798		19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 59,773			$ 59,773	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	MEDICAL SUPPLIES	4,100	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	3,251	$ (849)	15
16	V	39	ANCILLARY EXPENSE	10,377	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	8,229	(2,148)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 14,477			$ 11,480	$ * (2,997)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V							$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Maury Aaron	Owner	Administrative	21.60%	See Attached	4.1	8.16%	All-Dynamic	$ 47,296	17-7	1
2	Marshall Mauer	Owner	Administrative	6.07%	See Attached	3.5	7.02%	All-Dynamic	34,997	17-7	2
3	Sharon Aaron	Relative	Clerical		See Attached	3.51	8.77%	All-Dynamic	5,530	21-7	3
4	Sue Koplin	Owner	Administrative	2.85%	See Attached	6.3	14.00%	All-Dynamic	10,079	17-7	4
5	Dennis Nehmer	Owner	Maintenance	2.37%	See Attached	3.63	9.08%	All-Dynamic	5,644	6-7	5
6	Steven Goldstein	Owner	Administrative	12.14%	See Attached	15	30.00%	All-Dynamic	48,301	17-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 151,847		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	577,359	15	$ 10,580	$	49,771	$ 912	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	577,359	15	54,834	37,633	49,771	4,727	2
3	7	EMP.BEN. - GEN. SERVICES	PATIENT DAYS	577,359	15	11,326		49,771	976	3
4	13	NURSES AIDE TRAINING	PATIENT DAYS	577,359	15	1,650		49,771	142	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	577,359	15	23,811		49,771	2,053	5
6	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	577,359	15	14,469		49,771	1,247	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	577,359	15	588,891	487,646	49,771	50,765	7
8	24	SEMINARS AND TRAVEL	PATIENT DAYS	577,359	15	11,803		49,771	1,018	8
9	25	ADMIN. STAFF TRANS.	PATIENT DAYS	577,359	15	1,502		49,771	130	9
10	26	INSURANCE	PATIENT DAYS	577,359	15	47,685		49,771	4,111	10
11	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	577,359	15	94,969		49,771	8,187	11
12	30	DEPRECIATION	PATIENT DAYS	577,359	15	44,866		49,771	3,868	12
13	32	INTEREST	PATIENT DAYS	577,359	15	25,667		49,771	2,213	13
14	33	REAL ESTATE TAXES	PATIENT DAYS	577,359	15	24,936		49,771	2,150	14
15	35	EQUIPMENT RENTAL	PATIENT DAYS	577,359	15	102,054		49,771	8,798	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,059,043	$ 525,279		$ 91,297	25

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	12	62,194	62,194	4	5,644	1
2	10	NURSING CMP - SUE G.	WGHTD. AVG. HOURS	40	1	45,894	45,894			2
3	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	13	398,821	398,821	4	34,997	3
4	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	45	12	521,536	521,536	4	47,296	4
5	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	6	191,700	191,700			5
6	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	50	3	161,003	161,003	15	48,301	6
7	17	ADMIN. CMP. - S. KOPLIN	WGHTD. AVG. HOURS	45	8	71,993	71,993	6	10,079	7
8	17	ADMIN. CMP. - D. MAGAFAS	WGHTD. AVG. HOURS	45	8	81,938	81,938			8
9	17	ADMIN. CMP. - E. CASSON	WGHTD. AVG. HOURS	38	1	47,846	47,846	38	47,846	9
10	17	ADMIN. CMP. - S. BOGEN	WGHTD. AVG. HOURS	45	3	96,858	96,858			10
11	17	ADMIN. CMP. - S. LEVY	WGHTD. AVG. HOURS	55	13	139,807	139,807	5	12,269	11
12	17	ADMIN. CMP. - HOWARD ALT	WGHTD. AVG. HOURS	40	1	9,000	9,000			12
13	17	ADMIN. CMP. - NON-OWNER	WGHTD. AVG. HOURS	45	13	219,069	219,069	4	19,867	13
14	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	13	63,022	63,022	4	5,530	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,110,681	$ 2,110,683		$ 231,829	25

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40		4,545		4	412	1
2	15	EMP. BEN.- SUE G.	WGHTD. AVG. HOURS	40		3,924				2
3	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40		25,461		4	2,234	3
4	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	45		35,957		4	3,261	4
5	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45		22,028				5
6	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	50		20,193		15	6,058	6
7	27	EMP. BEN.- S. KOPLIN	WGHTD. AVG. HOURS	45		16,504		6	2,311	7
8	27	EMP. BEN.- D. MAGAFAS	WGHTD. AVG. HOURS	45		17,632				8
9	27	EMP. BEN.- E. CASSON	WGHTD. AVG. HOURS	38		11,976		38	11,976	9
10	27	EMP. BEN.- S. BOGEN	WGHTD. AVG. HOURS	45		6,849				10
11	27	EMP. BEN.- S. LEVY	WGHTD. AVG. HOURS	55		19,408		5	1,703	11
12	27	EMP. BEN.- HOWARD ALTER	WGHTD. AVG. HOURS	40		1,068				12
13	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45		29,449		4	2,671	13
14	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40		8,457		4	742	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 223,451	$		$ 31,368	25

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC REHAB CONSULTANTS, L.L.C.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	THERAPY	DIRECT ALLOCATION						1,260	1
2	19	PROFESSIONAL FEES	DIRECT ALLOCATION							2
3	22	EMPLOYEE BENEFITS	DIRECT ALLOCATION							3
4	39	ANCILLARY SERVICES	DIRECT ALLOCATION						43,360	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 44,620	25

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PHARMCOR, L.L.C.
Street Address: 3116 S. OAK PARK
City / State / Zip Code: BERWYN, IL 60402
Phone Number: (708)795-7701
Fax Number: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING & MEDICAL SUPPLY	DIRECT ALLOCATION						26,676	1
2	19	PROFESSIONAL FEES	DIRECT ALLOCATION							2
3	21	CLERICAL & GENERAL	DIRECT ALLOCATION						299	3
4	22	EMPLOYEE BENEFITS	DIRECT ALLOCATION							4
5	39	ANICILLARY EXPENSE	DIRECT ALLOCATION						32,798	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 59,773	25

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: LINCOLN MEDICAL SUPPLIES, INC.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	MEDICAL SUPPLIES	DIRECT ALLOCATION			$	$		$ 3,251	1
2	39	ANCILLARY EXPENSE	DIRECT ALLOCATION						8,229	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 11,480	25

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bank Leumi		X	Line of Credit	6/30/1998		1,000,000	612,000		8.75%	51,358	6
7												7
8												8
9	TOTAL Facility Related				$35,976		$ 1,000,000	$ 612,000			$ 51,358	9
	B. Non-Facility Related*											
10	See Supplemental Schedule											10
11	Interest Income										(12,734)	11
12	Allocation from Dynamic	X									2,213	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (10,521)	14
15	TOTALS (line 9+line14)						$ 1,000,000	$ 612,000			$ 40,837	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$	21

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.		$ 136,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 136,315	2
3. Under or (over) accrual (line 2 minus line 1).		$ 315	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 137,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 137,315	7

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	119,488	8
	1997	117,983	9
	1998	121,074	10
	1999	130,272	11
	2000	134,165	12

R. E. Tax Accrual: $134,165 X 1.02 = 136,848 (137,000 rounded)

Related Party Allocation = $2150

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CARRINGTON CARE CENTER LTD COUNTY KANE

FACILITY IDPH LICENSE NUMBER 0038802

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda (847) 236-1111

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-34-228-012-9	Long Term Care Property	$ 134,164.64	$ 134,164.64
2.	10-23-404-059-0000	Related Party Allocation	$ 24,139.10	$ 2,080.90
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 158,303.74	$ 136,245.54

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 41,038 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	26,220		20	1,312	1,312	10,669	9
10	Various			1994	118,541		20	5,928	5,928	45,173	10
11	Various			1995	26,846		20	1,343	1,343	8,902	11
12	Various			1996	35,440		20	1,772	(1,772)	9,798	12
13	Various			1997	129,052		20	6,454	6,454	30,368	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		38,240	980		1,093	113	9,105	68
69	Financial Statement Depreciation			29,379			(29,379)		69
70	TOTAL (lines 4 thru 69)		$ 374,339	$ 30,359		$ 17,902	$ (16,001)	$ 114,015	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 374,339	$ 30,359		$ 17,902	$ (12,457)	$ 114,015	1
2	SHELVING	1998	1,561		20	78	78	312	2
3	AIR HANDLER	1998	1,117		20	56	56	224	3
4	COOLING TOWER	1998	7,327		20	366	366	1,434	4
5	NEW CONDENSOR	1998	3,754		20	188	188	721	5
6	DOOR	1998	984		20	49	49	184	6
7	ELEVATOR	1998	12,500		20	625	625	2,344	7
8	WATER TOWER	1998	10,450		20	523	523	1,961	8
9	TRANSFER SWITCH	1998	2,179		20	109	109	400	9
10	FLOORS REHAB	1998	1,471		20	74	74	259	10
11	ELEVATOR PUMP & HOSE	1998	1,826		20	91	91	319	11
12	KITCHEN PIPE LINE	1998	7,806		20	390	390	1,333	12
13	MAGNETIC DOOR	1998	800		20	40	40	123	13
14	FIRE DAMPER	1998	2,040		20	102	102	315	14
15	TELEPHONE SYSTEM	1998	1,115		20	56	56	252	15
16	TELEPHONE SYSTEM	1998	1,363		20	68	68	295	16
17	PAINT & DECORATIONS	1998	3,143		20	157	157	471	17
18	FRONT DOOR	1999	1,395		20	70	70	210	18
19	FIRE DAMPERS	1999	1,499		20	75	75	225	19
20	FIRE ALARM	1999	586		20	29	29	80	20
21	MODULATING VALVE	1999	2,760		20	138	138	368	21
22	CIRCUIT SETTER	1999	1,096		20	55	55	147	22
23	CONDENSOR	1999	2,160		20	108	108	243	23
24	COOLER REPAIR	1999	3,925		20	196	196	441	24
25	FIRE ALARM REPAIR	1999	600		20	30	30	70	25
26	FIRE ALARM REPAIR	1999	902		20	45	45	101	26
27	CAMERA & MONITOR	1999	1,545		20	77	77	218	27
28	AIR CLEANER	1999	1,848		20	92	92	253	28
29	SPRINKLER REPAIRS	1999	1,397		20	70	70	210	29
30	ELECTRICAL WORK	2000	2,850		20	143	143	226	30
31	TILE	2000	660		20	33	33	52	31
32	TILE	2000	1,921		20	96	96	152	32
33	HANDRAILS/BUMPERS	2000	2,879		20	144	144	228	33
34	TOTAL (lines 1 thru 33)		$ 461,798	$ 30,359		$ 22,275	$ (8,084)	$ 128,186	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 461,798	$ 30,359		$ 22,275	$ (8,084)	$ 128,186	1
2	INSTALL HANDRAIL	2000	1,163		20	58	58	87	2
3	INSTALL HANDRAIL	2000	263		20	13	13	20	3
4	CUSTOM CABINETRY	2000	6,046		20	302	302	453	4
5	CARPET/TILE	2000	4,394		20	220	220	330	5
6	REMODELING	2000	9,180		20	459	459	650	6
7	TILING	2000	1,099		20	55	55	78	7
8	WALL SWITCHES	2000	1,631		20	82	82	116	8
9	DIALYIS ROOM	2000	411		20	21	21	28	9
10	REPLACE VALVE	2000	640		20	32	32	40	10
11	WINDOW TREATMENT	2000	2,366		20	118	118	138	11
12	WALLPAPER	2000	610		20	31	31	31	12
13	WALLPAPER	2000	2,325		20	116	116	116	13
14	WALLPAPER	2000	3,758		20	188	188	188	14
15	PAINTING	2000	7,790		20	390	390	390	15
16	FIRE ALARM	2000	706		20	35	35	35	16
17	GAS VALVE	2000	756		20	38	38	38	17
18	FAUCETS/PLUMBING	2000	611		20	31	31	31	18
19	SMOKE DETECTOR	2000	659		20	33	33	33	19
20	AIR CONDITIONING	2000	868		20	43	43	43	20
21	FREEZER REPAIR	2001	5,833		20	219	219	219	21
22	WALL COVERING	2001	1,655		20	55	55	55	22
23	BLINDS	2001	402		20	13	13	13	23
24	LIGHT FIXTURES	2001	604		20	20	20	20	24
25	WALL COVERING	2001	1,700		20	50	50	50	25
26	PATIENT TRANSPONDERS	2001	867		20	14	14	14	26
27	PATIENT TRANSPONDERS	2001	2,586		20	32	32	32	27
28	BOILER CONTROL	2001	912		20	4	4	4	28
29	1.6 AMP HORN	2001	630		20	29	29	29	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 522,263	$ 30,359		$ 24,976	$ (5,383)	$ 131,467	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 522,263	$ 30,359		$ 24,976	$ (5,383)	$ 131,467	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 522,263	$ 30,359		$ 24,976	$ (5,383)	$ 131,467	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 522,263	$ 30,359		$ 24,976	$ (5,383)	$ 131,467	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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17									17
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 522,263	$ 30,359		$ 24,976	$ (5,383)	$ 131,467	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 522,263	$ 30,359		$ 24,976	$ (5,383)	$ 131,467	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 522,263	$ 30,359		$ 24,976	$ (5,383)	$ 131,467	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 522,263	$ 30,359		$ 24,976	$ (5,383)	$ 131,467	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 522,263	$ 30,359		$ 24,976	$ (5,383)	$ 131,467	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 522,263	$ 30,359		$ 24,976	$ (5,383)	$ 131,467	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 522,263	$ 30,359		$ 24,976	$ (5,383)	$ 131,467	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 522,263	$ 30,359		$ 24,976	$ (5,383)	$ 131,467	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 522,263	$ 30,359		$ 24,976	$ (5,383)	$ 131,467	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1993		$ 38,240	$ 980	35	$ 1,093	$ 113	$ 9,105	4
5					Allocation from Dynamic						5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 38,240	$ 980		$ 1,093	$ 113	$ 9,105	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 258,395	$ 2,564	$ 25,545	$ 22,981	10	$ 146,141	71
72	Current Year Purchases	2,593	59	162	103	10	162	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 260,988	$ 2,623	$ 25,707	$ 23,084		$ 146,303	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Allocation from Dynamic		1900	$ 4,853	$ 264	$ 1,521	$ 1,257	5	$ 1,749	76
77										77
78										78
79										79
80	TOTALS			$ 4,853	$ 264	$ 1,521	$ 1,257		$ 1,749	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 788,104	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 33,246	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 52,204	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 18,958	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 279,519	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Carrington Building, LLC pays Fox Valley Health Care (Unrelated Party)

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions		206		747,241			4
5								5
6								6
7	TOTAL		206		$ 747,241 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$ 601,520
13.	/2003	$ 808,293
14.	/2004	$ 1,024,464

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 12,458 Description: $240 Beds; $420 Portable Freezer; $3000 Copier; $8798 Allocation from Dynamic
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Vehicle	$ 840	$ 10,082	17
18					18
19					19
20					20
21	TOTAL		$ 840	$ 10,082	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				Alloc.
7	Contractual Payments				Dynamic
8	Nurse Aide Competency Tests		142		142
9	TOTALS	$	$ 142	$	$ 142
10	SUM OF line 9, col. 1 and 2 (e)	$ 142			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 15,063	$		$ 15,063	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			5,488			5,488	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			22,809			22,809	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				41,605		41,605	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						28,031		28,031	13
14	TOTAL			$		$ 43,360	$ 69,636		$ 112,996	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 24,935	$ 24,948	1
2	Cash-Patient Deposits	50,609	50,609	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	527,209	527,209	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	60,464	60,464	6
7	Other Prepaid Expenses	7,535	7,535	7
8	Accounts Receivable (owners or related parties)	4,800	5,200	8
9	Other(specify): See supplemental schedule	109,448	130,048	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 785,000	$ 806,013	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	430,772	430,772	15
16	Equipment, at Historical Cost	267,257	267,257	16
17	Accumulated Depreciation (book methods)	(296,038)	(296,038)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	19,100	19,100	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(19,100)	(19,100)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 401,991	$ 401,991	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,186,991	$ 1,208,004	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 366,273	$ 366,273	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	50,609	50,609	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	209,186	209,186	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,611	3,611	31
32	Accrued Real Estate Taxes(Sch.IX-B)	137,000	137,000	32
33	Accrued Interest Payable	3,275	3,275	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	9,197	9,197	35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 779,151	$ 779,151	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	612,000	612,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 612,000	$ 612,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,391,151	$ 1,391,151	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (204,160)	$ (183,147)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,186,991	$ 1,208,004	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 380,590	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 380,590	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(584,750)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (584,750)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (204,160)	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,289,109	1
2	Discounts and Allowances for all Levels	(408,339)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,880,770	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	354,660	6
7	Oxygen	13,215	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 367,875	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	900	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	62,408	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,295	19
20	Radiology and X-Ray	1,193	20
21	Other Medical Services	64,719	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 135,515	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12,734	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 12,734	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See supplemental schedule	310	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 310	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,397,204	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,095,399	31
32	Health Care	2,462,394	32
33	General Administration	1,183,344	33
	B. Capital Expense		
34	Ownership	976,885	34
	C. Ancillary Expense		
35	Special Cost Centers	151,147	35
36	Provider Participation Fee	112,785	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,981,954	40
41	**Income before Income Taxes (line 30 minus line 40)****	(584,750)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (584,750)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Available If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,952	2,040	$ 63,411	$ 31.08	1
2	Assistant Director of Nursing					2
3	Registered Nurses	37,504	40,368	947,438	23.47	3
4	Licensed Practical Nurses	9,967	10,403	221,684	21.31	4
5	Nurse Aides & Orderlies	59,195	60,230	718,535	11.93	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,581	2,789	60,934	21.85	8
9	Activity Director	2,408	2,472	36,819	14.89	9
10	Activity Assistants	10,732	11,342	89,135	7.86	10
11	Social Service Workers	956	1,199	26,654	22.23	11
12	Dietician					12
13	Food Service Supervisor	3,881	4,289	70,623	16.47	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,098	25,403	204,274	8.04	15
16	Dishwashers					16
17	Maintenance Workers	2,981	3,269	33,943	10.38	17
18	Housekeepers	20,887	22,636	157,601	6.96	18
19	Laundry	12,591	13,258	112,845	8.51	19
20	Administrator	110	177	8,077	45.63	20
21	Assistant Administrator	96	96	1,346	14.02	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,653	8,286	102,743	12.40	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,430	4,855	48,945	10.08	31
32	Other Health Care(specify)					32
33	Other(specify)	3,048	3,335	37,551	11.26	33
34	TOTAL (lines 1 - 33)	205,070	216,447	$ 2,942,558 *	$ 13.59	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	12	$ 7,704	01-03	35
36	Medical Director	Monthly	19,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	2,064	12,312	10-03	38
39	Pharmacist Consultant	Monthly	4,298	10-03	39
40	Physical Therapy Consultant	19	1,040	10a-03	40
41	Occupational Therapy Consultant	4	220	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	53	2,340	11-03	44
45	Social Service Consultant	50	2,194	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,202	$ 49,608		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,636	$ 68,728	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides	9	384	10-03	52
53	TOTAL (lines 50 - 52)	1,645	$ 69,112		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Evonne Casson	Administrator	0	$ 8,077
Suzanne McIlvaine	Asst. Administrator	0	1,346
(Additional salary paid by related party)			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 9,423

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 23,332
Econocare	Purchase Consulting	3,708
Personnel Planners	Unemployment Consult.	1,336
Doctors Service Bureau	Collection Fees	288
Sachnoff & Weaver	Legal	16,166
Littler Medelson	Legal	33
Health Data Systems	Data Processing	4,118
Dynamic Health Care	Bookkeeping	321,210
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 370,191

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 65,503
Unemployment Compensation Insurance	24,838
FICA Taxes	223,216
Employee Health Insurance	61,378
Employee Meals	30,441
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits	14,653
TOTAL (agree to Schedule V, line 22, col.8)	$ 420,029

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	12,950
Health Care Worker Background Check	469
(Indicate # of checks performed 7)	
Advertising & Promotion	24,912
Dues & Subscriptions	9,776
Licenses & Permits	538
Allocation from Dynamic	1,247
Less: Public Relations Expense	
Non-allowable advertising	
Yellow page advertising	(6,100)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 43,792

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,470
Allocation from Dynamic	1,018
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,488

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number CARRINGTON CARE CENTER LTD # 0038802 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council on Long Term Care $8691**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **9,158** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? **X** YES ____ NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **112,785**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **30,441** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? ____ If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees